No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF PHILIP DREISBACH, M.D. AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

Philip Dreisbach is a physician specializing in Cancer and Hospice patients.

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SUMMARY OF ARGUMENT

The decision of this Court in this case will have effect in the 1990's and beyond. PVS is a catch all term used to describe a wide variety of people suffering a relatively wide range of different levels of brain injury from a wide variety of causes. Many of those PVS affected by this decision will have the increased opportunity to be helped given by 1990's medicine. 1990's medicine will be far more effective in helping the PVS than today's medicine. Today's treatment of the PVS is in its infancy, because yesterday's researcher's did not do substantial research in helping the PVS. Techniques used to assist injured athletes 30 years ago, such as electro stimulation (See Kanno, et al, infra) are just starting to be used on the PVS. The functioning of more than 100,000 chemical

and biological agents have to improve other body functions is partially understood. None of these have been tried on the PVS, but it is almost certain some will dramatically help some PVS.

Physicians suffer from the same imprecisions of thought as other humans. This Court should take care lest it reach the wrong decision because of physician imprecision of thought.

"People in coma and PVS states (similar to Cruzan) have functioning brain stems, but the higher functions of the brain are dead. These functions are located in..." Brain dead? Nonsense! If the cerebral parts of the brain were dead, nobody would ever recover from coma or PVS, yet some do. A few examples of such recoveries are included herein to prove that some do recover (and with better technology, probably many more

would recover). The most that can be claimed (and this unlike the "brain dead" statement agrees with all the known facts) is that certain parts of the brain are incapable of functioning in such a manner that we can detect the function. Each PVS patient is similar to a computer where there is a defect in the output mechanism. Without knowing more, we cannot say if the input systems or the internal processing of either computers or the injured PVS brains works. There are certain characteristics which define life and things that are alive. We know that the brains of at least some of those in coma or PVS were alive because they recovered at least partially. It appears, then that the only evidence available to us is that at least some of the PVS can be substantially improved by techniques the will soon be available.

ARGUMENT RE FUTURE PVS TREATMENT LEVEL

Physicians are competitive people. Some athletes may be able to make it on mere ability without being competitive, but to be a physician, one has to prepare for long hours during many years. Only the competitive have the persistence. This competitiveness carries over into practice. Physicians want to win.

In most cases this is good, but it causes problems in the case of the patient who is an almost certain loser. The treating physician feels like a loser when his patient loses, probably similar to the feeling of a lawyer who loses. ., Losing imposes a large emotional drain onto an already stressful profession. For this reason, most physicians have emotional problems relating to "losing" situations and there is a tendency for physicians to avoid losing situations

which means avoiding losing patients. For these unfortunate emotional reasons, patients like Nancy Cruzan have not been given the attention given to other patients. Read through the briefs of amici urging reversal and you will not find evidence that all that can be done for these patients in the area of research has been done. Just the opposite is true. As a rule, the PVS are fed and ignored.

Many years experience treating cancer patients enables one to understand how the sophistication of cancer treatment has increased. Reading the literature related to treatments designed to bring the PVS back to consciousness illustrates a shocking difference in sophistication. This is not meant in any way to criticize those presently doing research with the PVS. A midget sees farther than a giant

when he stands on the giant's shoulders. Today's cancer researchers are advanced because of yesterday's research. Today's PVS research in many ways is only as sophisticated as the cancer research of more than thirty years ago. Good research involves answering the simple broad questions first. These answers then suggest the next questions. Rockne or Lombardi may have been the greatest football coach, but even the NFL losers today know more about plays because they build on the past. What is shocking, even disgusting about the level of today's PVS research is that apparently yesterday's phys'cians were so emotionally repelled by the unconscious that it was not done then. Recently, we see cases of the PVS reviving with the proper stimulation. What sophisticated super modern medically advanced technique did it? Examples

include a pep talk from Dan Marino and the type of aggravation a clever two year old could use to wake her parent, such as massage, vinegar in the mouth, noises, etc. The tragedy is that these techniques are seen by some to be controversial.

How can something so simple be controversial? Why didn't we have the answers twenty years ago? How hard would it have been to perform these and more sophisticated experiments under experimental conditions in 1960 or when the technology was sufficient, so we would have had the answers then and would now be-thirty years more advanced?

If experience with the rest of the body is any guide, there are thousands of ways the brain can be injured to cause PVS, and each of these ways has one best way to cure it or mitigate the damages. If research had begun when it should

have, this case would not be here today, because when Nancy was injured, we would have known so much more we might have cured her, or in the alternative, we would know she was really dead, so there would be no controversy, and life support could have been turned off without promoting euthanasia.

Of course "if" is the biggest two letter word in the dictionary. The research was not done. We do not know precisely and completely what abilities her brain and mind have had since the accident. There is a conflict in the expert testimony about even basic differences. The Court must decide based on what it knows, not on what medical science should have learned, but did not.

What is known? What cannot be denied?

Some PVS, although unable to exhibit signs of upper brain activity, do hear

and do think and do remember, and do tell us about it later on when they wake up, and do recover meaningful functions. Because that research was not done yesterday, we do not in advance know which. It cannot be said with certainty that Nancy Cruzan has no potential for meaningful improvement based on research in the near future, since the results of future research is unknown. It cannot be said the the upper functions of the brain are dead, just that we are unable to communicate with them, except on a primitive level in Nancy's case. Perhaps a physical or chemical or hormonal or some other discovery will reverse the damage at least in significant part.

There is a story which is believed to be true that a war lord wanted to know the effect of no cuddling and talking on babies. He ordered a number of babies to

be fed and changed but not talked to or held or cuddled. The experiment has not been repeated because all the babies soon died. This is how many PVS are treated. Many years ago, research should have been done to determine how much later damage was done by the original injury and how much by this sensory deprivation (which could be avoided). Before astronauts went into space, there was much concern about sensory deprivation. How would they react to no walking or running, being kept cooped up in a small capsule in space with the resultant limitations. Experiments were run which proved that sensory deprivation does have an adverse effect on humans. Placing people in a dark area with no light, permitting them to hear nothing, giving them no variation in touches, smells, tastes and other environmental contact with their senses

has caused severe distress in a relatively short time.

This is analogous in some ways to an unconscious human. Many (but not Nancy) appear unable to open their eyes and see. They appear to be sleeping, so everyone politely refrains from talking to them, and they do not participate in conversations, even on the receiving end. They are bedridden, and do not do normal activities such as walking, running, swimming, dancing, etc. They cannot listen to a football game, rock concert or opera.

How does this relate to those in coma or PVS? Very closely to some of them. The human brain is one of the most complex entities in the known universe. The human brain in many ways is more remarkable and more unusual than the entire rest of the human body. Think of the many ways the

rest of the human body can be injured, with the vast number of types of damages and means such as physical, chemical, biological, etc. and the many techniques that can be used to cure or reduce the damage. Now compare the subtlety of the brain to the rest of the body. Look at the mouth. Even new born babies know what they are good for. Look at an arm or a finger. It is easy to understand what they do and to understand many ways they can be injured. When an arm broke, even primitive people could figure out what to do to give it a chance to recover.

Other body elements, systems and relationships are more complex. We cannot see germs with the unaided eye, so it is not surprising that their effect was not feared until understood. Look at some of the subtle organs. What savage seeing one such subtle organ could with only the

instruments available in his culture understand what they do, much less understand how they are injured or how to mitigate damage or cure. Without denigrating today's physicians, it is obvious that anything so marvelously subtle and complex as the human brain will be susceptible to a wide variety of injuries capable of causing unconsciousness. The fact that today's medical science has so few labels such as coma, PVS, and unconscious to describe these states is compelling evidence that knowledge of these injuries is in its scientific infancy.

It has been estimated that scientific knowledge is doubling every twenty years. Even more outstanding, it has recently been estimated that knowledge of the brain is now doubling every ten years. This may be true because only recently

have we had the subtlety to design instruments such as the various scans which enable us to scientifically examine many working or abnormal brain functions. Only recently have we begun to develop the variety of chemicals we now have to alter brain abnormalities. Anyone predicting what the knowledge of the brain of two, five or ten years from know will or will not permit us to do have as much chance of success as someone predicting the present day America the first time Columbus decided to sail west. It cannot be said today what the physicians of the near future will be able to do with Nancy Cruzan. Those who make such predictions are showing their political agenda, not their scientific or medical knowledge.

The history of science is littered with ridiculous predictions. Almost

whatever it was, the first airplane, radio, telephone, one can find some famous scientist who should have known better who said it could not be done just a short time before it actually was done.

Medicine, in part because of its connection with some of the most intimate human problems is littered with errors of the type made by those today saying that in a few years nothing will be able to be done with those brain injured we cannot help today. In 1973, this Court overlooked medical advances and legislated a super law under the guise of an unenumerated Constitutional "right" which a later Justice has said was on a collision course with itself. It should not repeat the 1973 error.

Consider some of the best medical advice given our forefathers. George Washington followed the best medical

advice available, yet probably died early because the "best" advice said to bleed him which did substantial harm to his body and contributed to his death. The market price of leaches has gone down substantially from previous centuries, since they are no longer considered a fantastic medical instrument. Last century, the knowledgeable women were attended at birth by midwives, not physicians. They did not know what physicians did wrong, but they knew that for some unknown reason they were far more likely to die if a prestigious physician attended their child's birth rather than a lowly midwife.

Our children will be able to say the same thing about us. Sometimes medical changes come flashing over the horizon like a meteor. An example is the discovery of Penicillin. Sometimes,

however, they rise slowly like a star, perhaps initially obscured by dirty air near the horizon, they come with the agony and controversy of a long term major political change. These changes begin with substantially all the medical establishment as represented by the alphabet soup of prestigious organizations all on one side of the issue, the wrong side, the incorrect side, the side that does much harm to society before the ever increasing volume of facts overwhelms them and consigns them to the dust bin of medical history where they would have gone sooner if they had been true scientists, rather than opinionated politicians with prestige and medical degrees. Each of these historical examples proves that the vast majority of physicians, possibly all of them are subject to the same emotionally caused

defects in intellect which affect other humans.

These errors are more likely to occur in the most sensitive areas such as the most critical times of human life, because physicians care more about these more important areas, and caring too much can cause one's vision to be obscured by one's emotions. In addition, in a more caring area, a physician who is wrong is more likely to discuss the matter with his peers, so that as is the case, if most physicians start off wrong, this discussion can for a time cause a large number to err.

There are many possible examples of the preceding unfortunate defect in the system of medical care improvement. Most of them are too obscure to be within the judicial notice of this Court, but some should already be known to this Court. If

you have become grandparents at the right time, you will recall that a generation ago, Nursing babies was frowned on by physicians. The La Leche League was formed about thirty years ago, and now many mothers nurse children until the age of two or longer, apparently to both their benefits. About twenty five years ago, during childbirth, the only good mother was a doped up mother and fathers were not even permitted to be present during this intimate family event. Many harsh words were spoken before the medical establishment admitted it had been wrong. The revolution occurred because mothers who knew began to educate other women with some of the most effective educating taking place in post birth rooms with one woman lying in bed with a post anesthesia headache and asking the other woman how she could feel

good enough to be up on her feet and anxious to leave the hospital the same day. Women began to select OBs who would cooperate. Many hospitals which would not cooperate had to go out of the child birth business.

In the area of care of the dying, especially the dying cancer patient, not too long ago very few cancer patients were told they were likely to die. Many were not even told they had cancer. This tragic breakdown in communication and paternalistic deliberate withholding of relevant information from the patient, was much too typical. Tragically, the subterfuge of silence did not work. Only the densest patient would fail to realize his plight if they removed a growth from his body, gave evasive answers to his questions, went out in the hall to discuss the really interesting stuff,

gave him treatments for cancer, etc.

Another recent error of the medical establishment, now hopefully little more than late twentieth century history is the use of pain killers in the wrong amounts as well as at the wrong times. The medical establishment through their monopoly over the most effective pain killers via their control over prescriptions used to routinely leave directions for so much of so much pain killer to be given dying patients each so many hours. Incredibly, for reasons known only to that medical establishment, the intervals between giving of the pain killers were too long. When one is ill, the very illness may cause tension. More tension can be caused by the change in conditions and environment. Still more tension can be caused if the physician prevented one from receiving enough pain

killer or prevented one from receiving it soon enough so that one felt substantial pain. Still more tension can be caused by other things such as nausea, fear, boredom, etc. The fact that one is not identical to all the rest of humanity plus all this tension can cause one's body to devour the pain killer at a different rate so that one feels pain. If it was the physician's own mother or daughter lying there in that bed, he would have had enough sympathy to learn when she needed pain killer and how much. Unfortunately, substantially all terminal patients lacked this relationship, so the average dying cancer patient in severe pain might have been brutalized by her own physician refusing to give her enough pain killer or to give it at sufficiently short intervals because the actuality of her need did not fit his preconceived

notions.

This was changed not through the medical establishment, but probably primarily through the efforts of Drs Cicely Saunders and Richard Lammerton in the original English Hospices, St Christopher's at Sydenham, in London and St Joseph's at Hackney in London. The greatest cause of the happy revolution probably was the writing of Dr Lammerton in 1973 of "Care of the Dying", foreword by Dr Saunders. If it was just any book, it would not have worked, but this book flashed like a meteor.

Dr Lammerton wrote in 1973: "p82, Not long ago we thought that a flat electro-encephalogram (ie the absence of any electrical activity in the brain) indicated that a man was dead. Now every intensive care unit has stories of people who were dead for weeks or even months,

and then began to recover." Much the same will soon be said about the PVS.

How frequent are these recoveries today? It is difficult to derive accurate statistical data. How frequent will they be tomorrow? That is even more impossible to know. With an estimated 5000 to 10,000 in fairly long term PVS and coma states, the sample is too small for the best statistical analysis. A sampling of some news stories indicates that their is at least enough hope for Nancy Cruzan so that her life should be spared by this Court. Examples of stories in sources which should be available for verification by this Court include:

"The first woman ruled brain dead enough for starvation in New York, Carrie Coons, recovered when nurses, irritated by the court order stimulated her." On the same day, wire service stories also

carried the saga of Brent Doyle´s recovery credited to a tape by football player, Dan Marino. ["St Louis Post Dispatch", 4/14/89, p2A]

Coons´ case parallels that of Jacqueline Cole who had a massive stroke and went into coma. "Doctors said she was unlikely to live and, if she did, she´d probably be a ´vegetable´.... On the 41st day of her coma, Jackie´s husband and children petitioned the court to turn off her life-support systems....But the end did not come. Six days after the court appearance, Jacqueline Cole ´woke up´.... Jackie can walk and talk again..." ["Redbook July, 1987, pp 90 et seq.]

"One study of comatose patients who recovered spontaneously found that 40 percent of the people who had been in coma at least two weeks had a satisfactory recovery. (Satisfactory

recovery means they can feed and dress themselves and enjoy some measure of independence." "´You look at patients and presumably there is nothing going on,´ says Dr Howard Eisenburg, chief of neurosurgery at the University of Texas. ´I mean, no output. yet after months they wake up. It´s fascinating" ["Omni, June 1986, p 18.] The story describes efforts to stimulate one of two groups in coma more than ten days to determine the efficacy of stimulation.

"Doctors, medical staff, and family members should talk to comatose patients, urges John L Puma, MD, and his associates at University of Chicago Hospitals and Clinics. Physicians handling comatose patients may not speak to them because the patient does not seem to hear or respond. But brain function tests indicate that some patients though unable

to respond, both hear and understand. And when cared for in silence, they may believe they are dead which could become a self fulfilling prophesy. In 'Archives of Neurology,'Dr La Puma's group reports success of an 'environmental enrichment' program in which all sixteen patients recovered from coma while in a comparable group of fourteen not in the program, eleven died. One recovered patient could recall much of what her family said to her during her fifty-three day coma but wondered why her doctor didn't speak to her. She remembered thinking while in her coma, 'Doctor, you never say hello to me. Why do you act as if I'm not here?'"
["Vogue" April 1988, p 166]

In June, 1988, Barbara Blodgett, pregnant, was in an auto accident. An abortion was rejected. About six months later in December, still in coma, she

gave birth. "And while doctors had held out little hope for her survival, Barbara had begun to emerge from the coma after the birth. By late January she was back at home with her husband, David...Even now, experts are at a loss to explain Barbara´s recovery. Dr William Blackerby, a Nashville head-injury specialist, has speculated that massive hormonal shifts triggered by the birth may have been responsible. But Dr Loren Winterscheid, medical director at University Hospital, has expressed doubt that there was any connection. ´There is no way of knowing when or how much a patient in a coma like Mrs Blodgett´s is going to recover´, he said." [People (Weekly) 2/27/89, p38-40]

"My body was like a broken transmitter, able to receive but not send any messages. If I wasn´t dead, I was at least blind and paralyzed, facts that

would have been extremely upsetting in any other state of mind. But in the benevolent atmosphere of my dream I felt more curiosity than alarm." (She goes on to describe in detail {including what she felt and heard} the paramedics taking her, and the emergency room scenes on March 24, 1984. In later days, she describes a number of details she heard or felt, including disappointment while in coma and apparently totally without higher brain function, sensory reception, emotion. "Goodbye....Goodbye....Goodbye.´ It kept ringing in my ears. Like a needle stuck between grooves in a record, it drove me crazy. I was so agitated....upset with Gina and Larry. I couldn´t believe they were going out to dinner and not including me! Okay I thought, I can´t walk, but there has to be a wheelchair somewhere. I´ve been

pushed around all day on a stretcher-couldn´t they have taken me to dinner on a stretcher? If they really loved me, they would have found a way to include me." She describes pain ("My throat ached, my arms throbbed, my head pounded")

A library search has turned up hundreds of published cases of people recovering froma PVS state worse in condition and ability than Cruzan is now in, although some of the recoveries involved patients in a worse state but not in the PVS state as long. Very few of these were published in the medical literature. (ie AMA brief claims 3 recoveries, but lists 4.) Sophistication level (See Kanno, Appendix) is low. We may be able to help most of the PVS.

NON MEDICAL ARGUMENT

I am reminded of a passage from the liturgy for Yom Kippur, the holiest day of the Jewish calendar. When the Temple still stood in Jerusalem – it was destroyed by the Romans in 70 A.D. – the high priest would enter the holiest inner sanctum one day a year, on Yom Kippur. He would enter it alone, and it was his duty to perform certain rites whose purpose was the atonement of all the people of the nation. In the years before the destruction of the Temple, there arose a controversy as to how the atonement procedure should be conducted by the high priest in the privacy of the holy chamber. The elders and the leaders of the people felt that the traditional way should be observed in every detail. This was no small academic matter to them. They felt that the welfare of the entire nation depended on this. Of course,

since he would be alone within the chamber, only the high priest would know whether or not he would properly fulfill his duty. So the elders, in preparing the high priest for his sacred mission, made him swear that he would not deviate from the traditional way of doing it. After extracting this oath from him, the elders would turn aside and weep. And then the high priest, too, would weep. The elders wept because they had to treat the high priest with suspicion. The high priest wept because they suspected him.

I am reminded of this passage, and I too sometimes feel like weeping, because it is now necessary to outline the case against euthanasia even to the U.S. Supreme Court. There was a time when it was inconceivable that this Court or even society at large would favor euthanasia. That is why the word "euthanasia" then

did not mean what it now does. Now favoring euthanasia is conceivable, and it even is legal in Holland. I fear that with the passage of time, our descendants will wonder that our society could ever have opposed it. I fear that they will look on our opposition to euthanasia as we now look on our society's previous legitimizing of slavery. That there should be fashion in morals is a contradiction in terms, but sadly it is an accurate description of the way the world is.

I do not oppose reversal because of any sloppiness in its language. It is not wrong, if you'll pardon the pun, in execution. It is wrong in concept.

Now, what does it mean to say that reversal is wrong? There are three main ways in which reversal could be wrong-minded. First, it could simply do more harm than good. This would mean that it

fails the simple test of utilitarianism. Second, it might be that reversal *per se* does more good than harm, but that it would likely lead to other societal changes whose harm would outweigh the benefit of reversal itself. These changes might be intangible, or they might be in the form of other laws or opinions broadening the areas in which euthanasia is permitted. This latter effect is sometimes called the "slippery slope." Finally, and most importantly, it is possible that reversal could do more good than harm, and yet be wrong because it is *intrinsically* wrong, not merely because it is *extrinsically* wrong. Obviously, such an argument patently rejects the utilitarian thesis that good acts are, by definition, those acts which yield the greatest good for the greatest number. If reversal fails on *any one* of

these levels, it should be rejected. I find that it fails on all three levels. Let us examine why.

First, I find that reversal does more harm than good, that is it fails the utilitarian test. How can this be? Consider that the number of people who would seek assisted suicide under reversal will be a very small percentage of those who experience terminal illnesses. Hope, or at least denial, springs eternal in the human breast. So the number of people who may "benefit" from reversal is small. Moreover, the *amount* of benefit that each would obtain from it is quite limited, since it is unlikely that, in most cases, more than a few weeks of suffering would be obviated by the assisted suicide. So we have a small number of people with a small potential benefit. But what harm could it do, you might ask,

since those who do not want assisted suicide would not be obliged to seek or accept it? The harm is this: all the terminally ill would be obliged to *consider* suicide, indeed more than consider, they would be obliged to *contemplate* it.

As you know, I am a cancer specialist who works with a hospice. As such, I deal with the dying on a daily basis. I have peeked through the keyhole of that doorway through which we all must pass some day. The dying have told me what it feels like to be dying.

Some of the emotions they feel will come as no surprise to you. Some of the dying fear pain. Some fear extinction of the self. Many worry what will become of their loved ones.

And perhaps some of the emotions they feel *will* come as a surprise to you. For the truth is that many of the dying

are concerned lest they depress their family or their doctor. Many are afraid of appearing cowardly. Many of them are *ashamed* to be dying. They are ashamed because it is considered a failure to die. They are ashamed because they are weak or even totally dependent, because they have become a burden to their family. They are ashamed because they are horrific in their cachexia, or because they are incontinent, or because they smell bad. They are ashamed because once they were beautiful, and now they are a thing of fear and loathing.

Such sentiments are not universal, of course. But they are common, far, far more common than the desire to be given a lethal injection. For despite their misery, the dying still cling to life. One of the great comforts, probably the greatest comfort, the dying have is the

loving care of others. The implicit message in this loving care is that despite their weakness, their ugliness, their odor, despite all this they are still valued. They are not, as they sometimes fear, worthless. Obviously, this worth attributed to them is not because of anything they can do, but rather because of what they are: living human beings. Their worth is intrinsic, not extrinsic. Loving-kindness is the antidote for feelings of worthlessness.

But what would the situation be in a society which allowed voluntary euthanasia? The message that such a society gives is that worth is extrinsic, not intrinsic. The message is that it's OK for the dying to be killed, because they're better off dead than alive. And, the message says, we're better off too. Such a society says that a snail darter may

not be killed, but a dying person may. Which has the greater value to that society?

Can you imagine how such a societal attitude would increase the suffering of the dying? (For now, thankfully, we *must* just imagine.) At a time when the dying are struggling to maintain a sense of worthiness despite their obvious uselessness, the society would be telling them just the opposite. The society would be saying, "You may continue to live if you like, but *we* see no reason why you must."

So reversal would increase the suffering of the dying in an immeasurable but very real way. It would do worse, though, than diminish the self-esteem of the dying. It would make the dying consider suicide not for their own sakes, but for the benefit of their survivors. The dying are aware of the medical ex-

penses they are generating. They are aware of the anguish their loved ones are experiencing. Why not end it all now to save the loved ones that money and trouble? If society says that it is acceptable to seek euthanasia, is it not selfishness to refuse to do so? Is it not causing economic and emotional grief to the survivors merely for the prolongation of a life that will soon end, a life which, in any case, society says is intrinsically worthless. Were society to relapse into this state of nature, life would truly be mean, nasty and brutish.

Thus, I find that reversal fails the test of doing the greatest good for the greatest number. Reversal does more harm than good.

But let us for the sake of argument grant that just the opposite is the case, that the bill does in fact meet the util-

itarian test. The next hurdle it must pass is the question of whether or not reversal would lead to further, and undesirable, erosion in societal standards. So let us assume that there is nothing in principle wrong with voluntary euthanasia of the terminally ill. If we grant that principle, then surely, we must grant that euthanasia should also be granted to the dying who are no longer able to express their desire for euthanasia, but who had expressed it clearly and often throughout their lives. Why, after all, should the expressively disabled be denied a right granted to their articulate counterparts? The principle is the same. To grant euthanasia to the expressively disabled, of course, we must rely on the testimony of family members who tell us that indeed euthanasia is what the dying relative had always wanted.

Should it not also, then, be granted to the PVS and those in a coma, since they too (we shall be told) had always said that they would rather be put to death than live on as a vegetable? The dignity of man, we shall be told, requires it in such cases. It follows logically, for the principle is the same.

But what of those people who develop hopeless dementia? They are not exactly dying, but any meaningful life is surely at an end. Many people feel that such a life is not worth living. Should not a demented person, one who had expressed a desire to live well or not at all, should not such a person be granted the same euthanasia as the physically dying? Admittedly, from time to time there will doubtless be cases in which the demented person is so confused that he resists the euthanasia he would surely have welcomed

were he lucid. But would it not be an ironic cruelty to deny that dement the balm of euthanasia merely because of this very confusion which is the reason for the euthanasia?

But old people are not the only ones, it will be argued, whose lives are no longer meaningful, who are really better off dead. Think of all the deformed and disabled babies born every year, children who will never be able to lead meaningful lives. Surely, if euthanasia is allowed to limit the suffering of the dying, should it not be allowed to limit the greater duration of suffering of the newborn deformed child? The principle is the same.

There are other deformities beside the physical, of course. It could well be argued – indeed it currently *is* argued – that a child born into a home where he

is unwelcome is really doomed to a life of misery. What a cruelty, then, to deny euthanasia to such children, to condemn them to a life of privation and rejection. If life is not worth living, then it is worth extinguishing. Again, the principle is the same.

And why should we restrict the benefits of euthanasia to either end of life? If a person has the right to choose to end his life when he is dying, should he not also have the right to end it when he is enduring other apparently intolerable suffering? Each man suffers at his own level, and surely society has no right to tell any individual that he must bear the suffering which is for him as onerous as that endured by the dying. If a society allows voluntary euthanasia for the terminally ill, can it legally, logically, or morally deny suicide to anyone else

who chooses it? I think not, for the principle is the same.

Is this slippery slope we have descended a *reductio ad absurdum,* or is it a logical conclusion? Perhaps it is both. If one starts with the principle that life is not intrinsically valuable, then it has only extrinsic value, or none at all. And remember: it is society, not the individual, that defines extrinsic value. Paradoxically, a reversal designed to enhance the autonomy of the individual ends by completely eliminating it.

It is not merely society at large which will experience an erosion of moral standards should the Court reverse. Most physicians remember our first exposure to the reality of pain and suffering, how it affected us at a visceral level. We still don't like seeing people in pain,

of course, but we can tolerate it now. Indeed, to be an effective doctor we *must* tolerate the sight of pain, and at times we must even knowingly cause pain if our purpose is to cure. One may argue whether this hardening of our hearts is beneficial or not, but one cannot deny that it has occurred as a result of our work. What will happen to these hard hearts of ours if euthanasia becomes a common practice? Will we not then grow hardened to medical killing itself?

Thus, even if this euthanasia *per se* is desirable, I believe reversal should be opposed because of the undesirable effects that will follow in its wake.

Now, I want to look at the third logical possibility, the third reason why someone might oppose reversal. That is, reversal should be opposed even if it does more good than harm and even if it

does not lead to undesirable consequences, because it is *intrinsically* wrong. Paradoxically, this is, I believe, both my strongest point, and my weakest argument. For here I must rely on such intangible and unprovable ideas as the sanctity of life, and the idea of life as a divine gift. Indeed, the former derives from the latter. I know I cannot prove these ideas to you, that logic alone will not support them. So I want to speak to the non-logical – not the illogical! – side of your brains; if possible, I want to speak to your hearts. I want to remind you of what you already know in your hearts: that we cannot create life, although we may be the instruments by which it is generated; and we cannot prevent death, although we may be the tools by which it is delayed. Life is, fundamentally, a precious mystery.

In the final analysis, or rather beyond the final analysis, we don't own life so much as receive life. Life is not a possession but a grace. Life is not ours to give. It is not ours to take.

CONCLUSION

The Court Should not reverse.

Respectfully submitted,

ROBERT L SASSONE, Attorney for Amicus

APPENDIX **ABSTRACT**

Effects of Neurostimulation on Reversibility of Neuronal Function: Experience of treatment for vegetative status

by

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Developments in the diagnostic procedures, micro-surgical techniques, intensive care, and the social rescue system have lowered the mortality in cerebrovascular diseases, head injuries and other emergencies of neurology and nerosurgery. However, this decreased mortality has given rise to a new social and medical problem i.e. vegetative status, which is an increase in the number of

people who live on with mild or severe residual neurological deficits.

During the last two years, we have used dorsal column stimulation (DCS) for improving spasticity of hemiplegics. While doing so, we incidentally found an improvement in the EEG in some of the cases. This led us to use dorsal column stimulation in cases of vegetative status. In this paper, we describe methodology and our experience with ten cases of vegetative status.

All cases satisfied the definition of "vegetative status" and had received medical treatment for more than 3 months prior to DCS without showing any clinical improvement.

A neurostimulator made by "Medtronic Neuro" was used. The neurostimulator was implanted in epidural space, in midline, at C-2 level under general anaesthesia.

Video recording of clinical conditions, EEG, rCBF and catecholamine metabolism in CSF at regular intervals were monitored to see the efficacy of this treatment.

Result:

1) There was an improvement in the EEG in nine cases out of ten cases after neurostimulation. This was in the form of appearance of more wide spread α-waves and was noticed between 3 to 14 days after starting the neurostimulation.

2) Four of these cases showed good clinical improvement. In the other four cases there was slight clinical improvement. They improved to the extent of following verbal orders within four months while another patient started opening eyes two weeks after starting the neurostimulation.

3) CT findings of all cases did not show any correlation with the amount of clinical improvement. However, we have not performed this stimulation for cases of which CT showed large diffuse low density area in cortex or brainstem.

4) Neurostimulation increased by rCBF by 20-40% at any parts of brain in cases of vegetative status. It increased not only in cerebrum, but also in cerebellum and brainstem.

5) Neurostimulation enhanced the metabolism of catecholamine in CSF, NE, DA, DOPAC, HVA, and 5HITAA increased, but 3MT and 5HT decreased in CSF. In conclusion, DCS increases rCBF, enhances the metabolism of catecholamine and improves EEG. These facts bring the clinical improvement of cases in vegetative status.

Reprinted from *Neurological Surgery*, Vol. 16, No. 2, February 1988. IGAKU-SHOIN Ltd. 5-24-3 Hongo, Bunkayo-ku, Tokyo, 113-91 Japan.